Patient Safety Programs Workgroup
"Roadmap to a Roadmap"
Draft
December 3, 2008

I. Introduction

Despite bearing some of the highest per capita health care costs in the world the overall health status of the citizens of Massachusetts is not commensurate. Gaps and variations in quality, efficiency and access must be addressed.

Under the auspices of the Health Care Quality and Cost Council's Patient Safety Committee, a workgroup consisting of thirty diverse stakeholder individuals/organizations has been convened to examine the key issues pertaining to Patient Safety in settings other than acute care hospitals and long-term care facilities. The workgroup will make recommendations to the Health Care Quality and Cost Council (HCQCC).

The basic principles underlying this effort include but are not limited to the following:

1. All persons who receive health care services must be assured that these services are of high quality – appropriate, **safe,** effective, equitable, efficient, timely and patient centered (IOM aims of excellent health care).
2. It is the responsibility of the health professionals rendering these services to provide competent care and appropriate timely documentation of the patient's treatment. It is also their responsibility to ensure appropriate timely follow-up care, referrals, and transitions across settings of care or handoffs.
3. Patients should be adequately informed of their treatment plan and provide appropriate consent for both the services rendered and the follow up arrangements. In all settings of care there should be mechanisms that encourage and facilitate the patient's ability to understand and comply with the plan of management.
4. The scope of the group's interest includes the elimination of medical errors through prevention efforts including systems changes.
5. The achievement of these aims requires the acceptance of "universal responsibility" – everyone must be involved in finding and implementing solutions. Caregivers should accept responsibility. It's about creating a "culture of safety".
6. The workgroup will identify in various settings of care actions that will have meaningful, sustainable, practical and measurable impacts on patient safety.
7. A goal is to identify and fully utilize those patient safety programs that are already in place and to build upon the efforts made in recent years by numerous organizations, providers and facilities.

II. General Principles and Concepts of a Patient Safety Program

Every organization (setting) and caregiver should be part of the patient safety movement, have an awareness of patient safety as a priority of healthcare service and participate in an appropriate patient safety program.

The recent development of PSO's should be fully investigated to further the development of PSO's as a mechanism to share and disseminate patient safety information.

A. Elements of a Patient Safety Program

1. Leadership is critical for patient safety

- Someone within the health care provider setting or contracted by the organization must be responsible for a patient safety program
- Different health care settings need to work closely with their professional associations/organizations to maintain and implement a patient safety program and seek necessary support
- Professional associations/organizations should also work closely with their members to provide support, including but not limited to, sharing tools, resources, best practices and lessons learned

2. Response Policy – every Patient Safety Program should have the basic elements in place to detect and respond to adverse events

- Mechanism(s) to analyze potential errors, learn from the events and take corrective action are essential. Any analysis must look for systems contributors, and not jump to blaming the individual or proposing retraining without correcting the systems problems.
- Peer review protections must protect all participants in error reviews from any legal or licensing ramifications based solely upon the good faith efforts to determine the cause of an error. Reviewers and the reviewed must feel safe to honestly share all information and perspectives. Actions against providers for errors by licensing boards and in tort actions may be based on records outside the error review process, which must be free to honestly evaluate the care provided.
- Mechanism(s) to monitor corrective actions.
- Professional associations/organizations should also work closely with their members to provide support, including but not limited to, sharing tools, resources, best practices and lessons learned

3. Prevention Policy –

- Every Patient Safety Program should have the basic elements in place to significantly reduce or eliminate those instances where a preventable adverse event occurs.

- Identifying vulnerabilities that can lead to adverse events/patient harm requires a – Risk Assessment Strategy
- Make necessary system and/or process redesigns to mitigate the risk of adverse events/patient harm is essential.
- Programs must make necessary "culture" and systems changes to ensure attention to and measurement of interpersonal and communication skills. This reinforces one of the core competencies required by the ACGME and now Joint Commission for facilities and should be adapted for use universally.
- Performance assessment should be accomplished using sound relevant data and sound methodology where available. It is important that assessment information be made available to the caregivers in a way that the care of patients can be improved prospectively

4. Patient Engagement –

- It is important to incorporate patient and family input in the identification of adverse events, and safety issues to resolve, and in the development of corrective actions.
- Approaches to implementing effective patient disclosure and apology policies should be part of any practice and are essential to any patient safety program.

III. Next steps

1. Continue to inventory settings, stakeholders, information and best practice sources
2. Listen to key stakeholder groups systematically – to date we have heard from the Coalition for the Prevention of Medical Errors, the Patient Safety Committee of the HCQCC, BORIM, DPH, CRICO, Etc. But there are many others to hear from over the next few months.
3. Communicate and coordinate our findings and recommendations with the many other workgroups, coalitions, medical societies, etc, especially the Transitions Workgroup.
4. Build and prioritize a schedule of useful, measurable, achievable quality/safety actions by setting with plans for implementation and performance measurement.
5. Complete 1-4 above by the summer of 2009.